Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	005008	A. BUILDING _____ B. WING _____	10/12/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST CATHERINE HOSPITAL INC	4321 FIR ST EAST CHICAGO, IN 46312

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS This visit is for 3 hospital complaint investigations. Complaint: #IN00093971 - Substantiated - no deficiencies cited #IN00090944 - Unsubstantiated - lack of sufficient evidence #IN00088007 - Unsubstantiated - lack of sufficient evidence Survey Date: 10/12/11 Facility: # 005008 Surveyor: Linda Dubak, R.N. Public Health Nurse Surveyor St. Catherine Hospital inc. is in compliance with 410 IAC 15-1.5-6, Nursing services and 410 IAC 15-1.5-2, Infection control, Hospital Licensure Rules. QA: claughlin 11/15/11	S 000		